increment approval letter (for initial and extended periods) to the facility.

Rate adjustments granted as a result of a request filed within 120 days after the costs were first incurred will be made effective retroactively to the date such costs were incurred. However, any adjustments granted as a result of requests filed beyond 120 days after the costs were first incurred will be effective on the first day of the month following the filing of the request.

PAYMENTS

The State of Rhode Island reimburses a provider monthly for Medicaid patient days time the assigned prospective per diem rate.

The State of Rhode Island reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

In determining the number of days for which payment may be made the date of admission is counted, however the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under State General Law Section 40-8.2-3 and Federal regulations, subsidy for patient care by either the patient, relatives or friends to the facility in any manner is

prohibited.

APPEALS PROCESS

Any provider who is not in agreement, after being provided an exit audit conference or rate appeal conference, with the final rate of reimbursement assigned as the result of the audit for their base year, or with the application of the Principles of Reimbursement for the applicable calendar years, may within 15 days from the date of notification of audit results or rate assignment file a written request for a review conference to be conducted by the Associate Director for Medical Services or other designee assigned by the Director of the Department of Human Services. The written request must identify the remaining contested audit adjustment(s) or rate assignment issue(s). The Associate Director for Medical Services or designee shall schedule a review conference within 15 days of receipt of said request. As a result of the review conference, the Associate Director or designee may modify the audit adjustments and the rate of reimbursement. The Associate Director for Medical Services or designee shall provide the provider with a written decision within 30 days from the date of the review conference.

Appeals beyond the Associated Director or the designee appointed by the Director of the Department of Human Service's will be in accordance with the Administrative Procedures Act. The provider must file a written request for an

Administrative Procedures Act hearing no later than 15 days of the decision noted in the paragraph above.

RECORDKEEPING

Adequacy of Cost Information

Providers of Long Term Care under the State Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable to substantiating the reasonableness of specific reported costs. Records include all ledgers, books and source documents (invoices, purchase orders, time cards or other employee attendance data, etc.). All records must be physically maintained within the State of Rhode Island.

Census Data

Statistical records supporting both Medicaid and total patient days must be maintained in a clear and consistent manner for all reporting periods. The detailed record of all patient days must be in agreement with monthly attendance reports and shall be the denominator used in the computation for determining per diem rates providing that said patient days are equal to or greater than 98% of the statewide average occupancy rate of the prior calendar year. In calculating patient days the date of admission is counted as one

day, however, the date of death or discharge is not counted as a day. See page 59 on Excess Bed Capacity.

AUDIT OF PROVIDER COSTS

In accordance with 45 CFR-250.30 p.(3) (ii) (B) all cost reports will be desk audited within six months of submission.

The State of Rhode Island, Rate Setting Unit, shall conduct audits of the financial and statistical records of each participating provider in operation during calendar year 1989.

Starting with the reporting year 1991 and with every reporting year thereafter, one-third of the participating facilities will have a new base year. The prospective rate of each facility with a new base year will be recalculated after the completion of an audit and will be effective July 1 of the year subsequent to the year in which the audit was scheduled. The recalculated rate will reflect the actual allowable costs as determined by the audit updated by the percentage increase(s), if applicable, for the year(s) subsequent to the audited year to produce the prospective rate, provided, however, that the new prospective rate does not exceed the maximum rates established for each cost center ceiling.

Audits will be conducted under generally accepted auditing standards and will insure

that providers are reporting under generally accepted accounting principles.

Other matters of audit significance which will be undertaken are the examination of construction costs and final cost reports. All costs of new construction will be audited by the State as herein described. Final cost reports submitted by a provider due to change in ownership, closing of a facility or discontinuance in the Medicaid Program shall be subject to audit within a reasonable time after such change has taken place.

Services and affiliated organizations where common ownership exists shall also be subject to audit. The extent of the audits will depend primarily on the relative dollar impact of these service groups (see page 55 for definition of service and affiliated organizations).

Audits will include any tests of the provider's records deemed necessary to ascertain that costs are proper and in accordance with Medicaid principles of reimbursement and that personal needs accountability is in compliance with existing regulations. The knowing and willful inclusion on non-business related expenses, non-patient related expenses, or costs incurred in violation of the prudent buyer concept may be subject to criminal and/or civil sanctions. Failure of auditors of the Department to identify the above items or their adjustment of same shall not constitute a waiver of any civil or criminal penalty.

OPERATING COSTS

DEPRECIATION

General

Reasonable costs incurred in providing services to Medicaid patients include depreciation on the building, equipment and transportation vehicles used to carry out necessary services. Following are the prescribed procedures for determining the allowable depreciation.

Capitalization Policy

The following policy on expenditures for depreciable assets is applicable regardless of standards established by the provider. Individual assets with a cost of $300.00 or more and a useful life of at least two years must be capitalized. Assets acquired in quantity at a total cost of $500.00 or more and multiple purchases of similar individual assets during a reporting period must be capitalized if the total cost is $500.00 or more and the assets have a useful life of at least two years.

Painting, redecorating or renovating, whether interior or exterior, of the entire facility or of a substantial portion of a wing or floor must be capitalized.

Method of Depreciation

For reimbursement purposes, only straight-line depreciation is permitted. This method provides for ratably charging to operations the actual asset cost less salvage value based on useful life.

The useful life of each asset will be subject to the American Hospital Association useful lives schedule (see Appendix 'B').

Component depreciation will be allowed subject to and with written approval of the Rate Setting Unit. In conjunction with component depreciation, allocables and other fees, services and items which cannot be specifically identified to a particular component will be depreciated on the basis of a forty (40) year life. Examples of allocables are, but not limited to the following: Architect fees, interest, real estate taxes and insurance during the time of construction, builders' overhead and profit, title fees, legal and recording fees, bond premiums, site studies and surveys, financing fees, etc.

Cost Basis for Depreciation Purposes

Asset acquisitions during a facility's base year will be annualized for prospective calendar years if the depreciation claimed for the base year is less than a twelve-month period.

Newly Constructed Facilities and Expansion of Existing Facilities

Construction costs approved by the Department of Health will constitute the maximum basis on which depreciation may be calculated subject to the maximum ceiling imposed under other property related expenses cost center. Costs must be bona fide, properly supported, and will be subject to audit by the State.

The useful lives of assets as approved by the Rate Setting and Auditing Unit may not be changed by the provider without prior authorization in writing from the Rate Setting and Auditing Unit. If such a change is approved, it will be effective July 1 of the year following the year in which the request was filed.

Demolition Costs

Demolition costs incurred for new construction and/or expansion are to be considered as follows:

a. Demolition cost and the recognized undepreciated base of a facility that was participating in the Medicaid Program just prior to demolition will be added to and become part of the new depreciable base of the new facility.

b. Demolition cost of a structure not previously enrolled in the Medicaid Program will be considered as site development costs and be added to cost of land.

Purchased Facilities

The cost basis of a facility and its depreciable assets acquired as an on-going operation in a bona fide sale, will be limited to the lowest on the following:

1. fair market value of buildings, improvements and tangible assets purchased,
2. price paid by the purchaser,
3. current reproduction costs depreciated on a straight-line basis over the useful life of the assets to the time of sale,
4. the valuation of capital assets (excluding furniture, fixtures and equipment, which shall be the lesser of sale price or net book value) will not increased (as measured from the date of acquisition by the seller to the date of the change in ownership) solely as a result of a change of ownership, by more than the lesser of: --

(i) one-half of the percentage increase (as measured over the same period of time) in the Dodge Construction Systems Costs for Nursing Homes, or

(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States City Average).

The cost basis of buildings, improvements and other depreciable assets in a sale that is not a bona fide sale, cannot exceed the seller's cost basis, less accumulated

depreciation. The burden of proof of whether such sale is or is not bona fide will rest upon the purchaser.

Whenever the allocation of cost to acquired assets appears unreasonable, independent appraisals of property values will be obtained by the Department of Health for the purpose of assigning cost values.

Costs associated with the sale and acquisition of capital stock will not be recognized for reimbursement purposes. Re-evaluation of assets will not be recognized nor will the financing cost attributable to the stock purchase. The amount of depreciation expense and interest expense to be recognized for reimbursement will be the amount recognized by the Rhode Island

Medical Assistance Program as remaining to be amortized prior to the stock acquisition.

Transfer of Ownership, Real Estate Holding Entities and/or Operating Entities Among Related Parties

Where there is a transfer or sale of corporate stock or transfer or sale of ownership from corporate officer(s) to other corporate officer(s), from partner(s) to partner(s), or between parties in which these is a common ownership the basis and approved method of depreciation, and the reimbursable interest cost prior to said transfer will be allowed the new owners.